Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: May 31, 2023	
Inspection Number: 2023-1367-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partn	
Long Term Care Home and City: Garden Terrace, Kanata	
Lead Inspector Karen Buness (720483)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 4, 5, 8, 9, 18, 19, 25, 2023
The inspection occurred offsite on the following date(s): May 10, 24, 2023

The following intake(s) were inspected:

- Intake: #00008201 - Complaint related to resident care and services
- Intake: #00013704 - Alleged staff to resident sexual abuse
- Intake: #00015594 - Complaint related to alleged staff to resident physical abuse
- Intake: #00017552 - Alleged staff to resident neglect.
- Intake: #00017567 - Complaint related to alleged staff to resident neglect
- Intake: #00084662 - Complaint related to discharge of resident
- Intake: #00085656 - Complaint related to resident responsive behaviours

The following **Inspection Protocols** were used during this inspection:

- Resident Care and Support Services
- Medication Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Residents' Rights and Choices
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (b)

The licensee failed to ensure with collaboration of the appropriate placement co-ordinator alternative arrangements for the accommodation, care and secure environment required by the resident were made before discharging a resident under subsection 157 (1).

Summary and Rationale
On a specific date a resident was transferred to hospital following an incident of aggressive behaviour towards co-residents and staff. The resident had a history of responsive behaviours and required one to one care to ensure the safety of other residents. The Director of Care (DOC) reported the licensee originally received notification that the resident was accepted and would be admitted to an alternative treatment facility. On a later date the licensee received notification from the hospital that the resident did not qualify to be admitted to the alternative treatment facility due to not meeting the admission requirements and stated that the resident would be discharged back to the LTC Home. The licensee informed the hospital that the resident would be discharged from the home as the home could no longer provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who came into contact with the resident. The Resident was then discharged from the LTC Home.
Requirements on licensee before discharging a resident under O'Reg 246/22 s. 161 (2) (b) states before

discharging a resident under subsection 157 (1), the licensee shall,
in collaboration with the appropriate placement coordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident.

Impact/Risk
Failure of the home to ensure alternative arrangements required by the resident were in place prior to discharge resulted in the resident being admitted to an acute care hospital and impacted the resident's quality of life.

Sources
Resident clinical health record and interviews

[720483]